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The negative consequences of over-diagnosing attachment disorders in adopted children.

Abstract

In many child services across health, education and social care, 'attachment disorder' remains a preferred description and explanation for the complex presentation of children who have been neglected or maltreated and is frequently used to describe the presentation of adopted children. Very often the use of this term bears little resemblance to the established diagnostic systems, nor indeed to attachment theory as conceptualised by Bowlby. At the same time, high quality developmental research is challenging our current understanding of the diagnoses of Reactive and Disinhibited Attachment Disorders on several fronts. The uncertainty about the attachment disorder construct can pose problems for clinicians working with adopted and fostered children in particular. The current paper briefly reviews the practical difficulties with the attachment disorder diagnosis as applied to adopted children and uses four case studies taken from a Tier 4 Adoption and Fostering Service to highlight some of the specific problems for services working with adopted children. Finally we propose some recommendations for the assessment and treatment for adopted children and their families, which aim to be consistent with attachment theory as well as the existing evidence base and emerging research.

Keywords

Attachment disorder; adoption; mental health

There has been increasing interest in the area of attachment disorder in the light of findings from the series of studies of Romanian adoptees (e.g., Rutter, Kreppner, & Sonuga-Barke, 2009; Zeanah & Smyke, 2008; Minnis, Marwick, Arthur & McLaughlin, 2006). However there is a growing mismatch between the rigour of academic studies and the application of the attachment disorder construct on the ground. While there is widespread use of the term 'attachment disorder' by services directed at adoptive families and foster carers, there is little scientific or diagnostic consistency in the way in which the term itself is used in these contexts (Nilsen, 2003). Frequently the constructs used bear little resemblance to the diagnostic categories that exist in DSM-IV-TR and ICD-10 (Prior & Glaser, 2006) and there is particular concern about some of the ineffective and even dangerous treatments that have followed from its use (Chaffin, et al., 2006; AACAP, 2005; Hanson & Spratt, 2000), which raises issues about how clinicians can use them in practice (DeJong, 2010).

The use of recognised diagnostic terms offers reliability and common understanding but the attachment disorder construct is complicated by the fact that the proposed aetiology forms part of the diagnosis (Zeanah, 1996). Both subtypes of Reactive Attachment Disorder in DSM-IV-TR and the related diagnoses of Reactive Attachment Disorder (RAD) and Disinhibited Attachment Disorder (DAD) in ICD-10 refer to the role of pathogenic care occurring before the age of 5 (see Prior & Glaser, 2006). So there is a risk of diagnosing some form of attachment disorder in samples of children who have been subject to early loss or trauma based primarily upon their caregiving history, without giving due attention to their current presentation. This risk is compounded by the availability of on-line checklists and questionnaires that identify the over-inclusive versions of attachment disorder using long lists of symptoms that span several recognised diagnoses, including conduct disorders, autistic spectrum disorders, learning disability, ADHD etc. (Prior & Glaser, 2006) resulting in the over-diagnosis of attachment problems at the expense of more common disorders. This is the case, even though clinicians have been advised to avoid the 'lure of the rare disorder' (Haugaard, 2004) and to consider more everyday disorders such as conduct problems, mood and anxiety in samples of maltreated and neglected children (Chaffin, et al., 2006).

It is important for clinicians to keep the distinctions between attachment disorder, attachment patterns, disorganised attachments and attachment difficulties distinct, along with their respective evidence bases (see Prior & Glaser, 2006; O'Connor & Zeanah, 2003). There is also the inappropriate description of a parent's relationship to their child being referred to in attachment terms, especially in assessments for Court (e.g., "What is the carer's attachment to their child?"), or indeed for the child's relationship to non-attachment figures or even inanimate objects. It is important to recall how Bowlby described attachment security deriving from the child feeling safe and protected by their tie to its carer, not vice-versa (Bowlby, 1958; Bowlby, 1982). Within the developmental psychology literature the attachment construct has a precise operationalisation, with a sense of protection and safety, quite distinct from the vernacular equivalent of 'relationship' that is often used in clinics and children's services (Goldberg, Grusec, & Jenkins, 1999). Similarly, the meaning of attachment disorder in the diagnoses of RAD and DAD refers to a pathological breakdown in the normal attachment system that an infant or young child develops with its caregiver and not just problems within the infant-carer relationship.

To some extent the problems with the construct of attachment disorder that we will illustrate in this paper have probably developed in the context of an absence of effective terms to describe the sometimes bizarre and atypical presentations in children, including looked after and adopted children, who have been subject to early disruptions in their attachment relationships or exposure to significant and persistent traumas within the caregiving relationship. The research literature has recognised this difficulty. For example, Zeanah and colleagues have proposed a range of putative clinical presentations that could indicate degrees of disordered attachment, including role reversal and compulsive compliance (Boris, et al., 2004; Zeanah & Boris, 2000). While there have been some attempts to think about the assessment of the relationships that drive secure attachments (Zeanah & Benoit, 1995) and an attempt to categorise problems at the relationship level (Zeanah & Smyke, 2008), such relationship disorders are not the same as the child's specific attachment to a particular carer or the presence of an attachment disorder within the child. In a further complication of the picture, while the distinction between the two forms of attachment disorder in ICD-10 is well-made, recent research suggests that DAD may be best

construed not as a malfunction of normal attachment processes but as a neurodevelopmental disorder (Rutter, et al., 2009).

There is clearly cutting edge research going on in this field to further refine various attachment constructs but in the meantime we are left with diagnostic categories within the ICD-10 and DSM-IV-TR systems that can be hard for clinicians working with adopted, fostered and maltreated children to make consistent and reliable use of (Boris, et al., 2004). Fortunately, there have been some helpful guidelines suggested by Prior and Glaser, consistent with recommendations made by O'Connor & Zeanah (2003) and two sets of American practice parameters (Chaffin, et al., 2006; AACAP, 2005) to guide the clinical application of attachment disorder in a way that is also consistent with Bowlby's original proposal. Concerning ICD-10, Prior & Glaser suggest that there needs to be evidence that the attachment system has failed and that no discriminated attachment figure has been achieved, e.g., the absence of an effective attachment figure to whom the infant or young child seeks proximity and comfort (RAD) or the lack of a specific, discriminated attachment figure (DAD). Whatever else, there needs to be good evidence that it is the attachment system itself that is not functioning, rather than the presence of behaviours that could be explained by non attachment-specific factors such as the result of exposure to trauma, other common psychiatric disorders or neurodevelopmental problems. Moreover, it is unhelpful to think of an 'attachment disorder', distinct from one of its recognised forms of either DAD or RAD in ICD-10 or RAD-Inhibited or RAD-Disinhibited in DSM-IV-TR. Furthermore, the scarcity of RAD and DAD diagnoses should be emphasised, even in groups at high risk of early pathogenic care such as looked after and maltreated children (e.g., Meltzer, Gatward, Corbin, Goodman, & Ford, 2003; Boris, et al., 2004).

Large scale research into the health and well being of looked after children in the UK has identified the types of disorders commonly seen. While there are bound to be some differences between adopted and looked after samples, most adopted children will have come through the looked after system, for at least some part of their lives, and as such the data from these studies can guide us to the likely range of disorders and diagnoses to consider for adopted children in the UK (Meltzer, et al., 2003; Ford, Vostanis, Meltzer, & Goodman, 2007). For example, looked after children have

significantly elevated rates of conduct problems and ADHD, compared with both high risk and normal controls in birth families (e.g., 39% vs. 10% and 4%, for behavioural disorders respectively and 8%, 1% and 1% for hyperkinetic problems respectively, Ford et al, 2007). These are disorders for which well-established care pathways using evidence-based treatments already exist. The same research also looked at the prevalence of attachment problems. Using a narrow definition that maps well onto the ICD-10 disorders, only 2% of Looked After Children were identified as having a possible attachment disorder, whereas about 16% were identified with a broader set of attachment related problems that went beyond the ICD-10 diagnoses (Meltzer, et al., 2003).

The following section is concerned with the use of the attachment disorder construct to adopted children and seeks to highlight the problems that can arise when professionals go beyond the evidence and succumb to the lure of rare disorders (Haugaard, 2004). It takes the form of four recent case vignettes taken from adopted children who have attended a National Adoption and Fostering Service.

Case Study 1

A is an 8 year-old boy who had lived with his birth mother until he was 2½, when he was removed to foster care due to neglect, domestic violence in the home and parental substance misuse. He entered his adoptive family aged 4. He presented with problems in the home of aggression, defiance, lying and nightmares, but no significant problems at school where, initially a victim of bullying, he was now settling in. His behaviour at home was severely disruptive and the placement was in danger of breakdown. During assessment A presented as inhibited, with low self-esteem, describing himself as sad and anxious with difficulties making friends at school and occasionally prone to becoming very angry. Formal psychometric assessment indicated that he had some specific learning disabilities in the context of a normal IQ. He received a diagnosis of ADHD and conduct disorder confined to the home but neither of RAD or DAD.

However, A's parents understood his problems solely in terms of attachment disorder. They had read about this extensively, had undertaken several courses pre-adoption and described themselves as experts in parenting who were better

informed than birth parents because of these courses. Their understanding of attachment disorder meant that when A was polite or helpful his behaviour was understood as manipulative and controlling, or 'faking good'. The parental criticism was explicit and pervasive. For example, the parents would explain to guests that his polite behaviour was insincere and he was only doing this to manipulate them. His parents reported being proud of friends who knew the family situation well-enough to say to A when he had offered them some crisps: "Don't think I don't know what you are really like, I know you are just trying to control me and I won't let you do that".

This explicit criticism of a child who was already sad and anxious decreased his weak and fragile self-esteem further. Such parenting also failed to notice the times when he was good and seeking love and approval from his parents. Doing this meant that A was not seen as who he was, but rather rigidly as who he was construed to be based upon a belief that his history of maltreatment had fundamentally damaged him. In fact they were parenting a hypothetical child derived from books and courses, rather than the real child who lived with them. Of course, this style of parenting was low in the sensitive responding that evidence suggests is crucial to developing a secure attachment to his new carers (Bakermans-Kranenburg, van Ijzendoorn, & Juffer, 2003).

The therapeutic work with these parents was primarily focussed on a social learning theory based parenting approach to increase sensitive responding and thereby address the behavioural problems due to hyperkinetic conduct disorder. Work was also done with the parents to challenge their beliefs and attributions about the meaning, and in particular the origins, of his behaviours. This approach enabled them to increase the amount of positive time spent with him, to 'catch him being good' and so increase his confidence in them as his forever-parents. Their own confidence in managing his tantrums increased and they responded to him in the here and now, as he actually was and not according to theories they had absorbed pre-adoption. At the same time, the neurodevelopmental contributions were addressed. First, medication for hyperkinesis facilitated the implementation of the parenting strategies. Second, the presence of specific learning disability in context of normal IQ indicated liaison work with his

school to ensure remedial help targeted his specific weakness in literacy. His teachers had assumed A had global intellectual delay but his presentation at school was a combination of inhibition plus poor literacy and some recovering language delay. As the placement stabilised, A was engaged in further CBT work with a primary trauma focus, but also with components to address affect regulation and his low self-esteem. It was important that the 1:1 work was begun after the parenting work to ensure it was part of a package working with the whole family system to avoid validating the parents' initial beliefs that had pathologised the child.

These were not intrinsically bad parents. Rather they had been led to believe in a simplistic construct of a damaged child, with a damaged brain, whom they needed to fix by drastic measures. In fact, they were edging towards a level of emotional abuse requiring a safeguarding framework. But was this their fault? Like many adopters they sought out as much help as possible with attachment prior to adoption (Barth, Crea, John, Thoburn, & Quinton, 2005), and their style of parenting had emerged out of their interactions with adoption professionals. As clinicians we need to understand how parents come to hold such extreme and unhelpful ideas, often taken from other professionals, and to be able to challenge them constructively, with evidence, including from attachment theory and research, which moves the focus away from an *a priori* expectation of damage and danger to be able to see each unique child as they are. In that way we can work with the family to devise a new understanding of the child's developmental trajectory, including where they have come from but also the range of likely outcomes, based on a detailed and individualised assessment. Such assessments are also likely to help with the child's educational career, as the next case highlights.

Case Study 2

B is a 10 year-old boy, removed from his birth mother who had learning disability at 18 months due to severe neglect and suspected sexual abuse. He entered his adoptive family aged 3½. B exhibited violent outbursts, especially towards his adoptive mother, that were largely unpredictable except that many occurred around going to school. However, he would show remorse afterwards, saying he was a bad person, that he hated himself and expressing a wish to die. These were not empty threats, as they had on occasion been

accompanied by significant self-harm incidents. B had pervasive difficulties with peer relationships, and was unable to make or sustain friendships, even with the active involvement of his parents and their extended network of families with same-aged children. He had better relationships with adults who were more likely to accommodate his unusual presentation which included odd speech, with stereotyped phrases, but in the context of an appropriately friendly manner with good prosody and modulated affect.

B was approaching the last year of primary school. His parents believed he was struggling at school and this was causing his distress. His school did not share this view and reported that he was attaining his literacy targets at precisely the level expected for his age and that he did not pose significant problems with management. Formal psychometric and neuropsychological testing in the clinic revealed a complex intellectual profile, characterised by particular deficits with language and verbal memory. The formal literacy testing indicated he was significantly behind his same-aged peers, achieving scores three to four standard deviations behind age and ability expectations, rendering him effectively illiterate.

His initial diagnoses included unsocialised conduct disorder and specific disorders of speech and language. Although he had many symptoms suggestive of an autistic spectrum disorder, this had been previously ruled out by local services on the basis of gold-standard assessments, although the recommendations were that B "be managed as if he had ASD". Similarly, although he had a disrupted attachment history, he did not meet criteria for either of RAD or DAD, showing specific and selective attachments to both his adoptive parents, albeit of an unusual quality.

When the discrepant findings from the clinic's attainment assessments were put to school, they admitted that they had deliberately avoided identifying any learning difficulties, "estimating" his literacy attainments as normal rather than assessing them. They claimed B "already has an attachment disorder because he is adopted" and they wanted to avoid labelling him further. A school visit revealed his behaviour was managed by keeping him isolated from

his peers. He was placed apart from his classmates with a volunteer teaching assistant and each breaktime he was removed from his peers to a room with a senior teacher, where he was allowed to play with desirable toys. Hence, he had very little contact with his peers in a highly structured environment provided by volunteer help outside of the framework of a Statement of Special Educational Needs.

The school and education authority initially challenged an application for a Statement and commissioned a brief psychology report, which did not include any psychometric assessment. This report disputed that he had either specific or global learning disability and asserted that any learning difficulties were entirely attributable to attachment disorder. Consequently, his difficulties were "not an educational issue". During feedback from this assessment his parents reported that they were told his problems had arisen because they "did not love him enough". In fact, his parents had been very committed to this child, and alongside advocating strongly for his needs to be met, they had consistently engaged with all the post-adoption therapeutic input that had been offered to them from local services, as parents, as a family and for the child himself. Over a year later, agreement was reached amongst the statutory services and B was given a specialist residential educational placement suitable to his level of social and adaptive functioning. He adapted extremely well and engaged with the modified curriculum, and both his behaviour and his relations with his family improved significantly.

This case study highlights a number of issues. There can be great value conducting a comprehensive neuropsychological assessment to identify complex and unusual neurodevelopmental profiles, not least because we know that early experiences of neglect and maltreatment can have various and unusual impacts upon the developing brain (McCrory, De Brito, & Viding, 2010). It also highlights problems working with different systems, with very different approaches. In this instance, the educational framework insisted upon an attachment based formulation to explain all B's difficulties, while social care resisted becoming involved again with an adopted child who had found a permanency placement outside of care. Finally, the safe management of B's severe aggression was achieved in our clinic through the unusual step of

prescribing adult antipsychotics. This temporary measure, designed to last only until the multi-agency system developed an effective long-term management plan, improved B's behaviour significantly at home and school. Unfortunately an unintended consequence of this acute pharmacological management was that it delayed the final decisions because the remainder of the system were happy to keep him on this medication indefinitely rather than plan beyond short-term crisis-management.

As with A's adoptive parents above, the school was attempting to act in B's best interest with regard to their particular understanding of attachment problems. They were certainly not attempting to exclude him or to discriminate against him. However an unintended consequence was that a child who was patently unsuitable for mainstream education was on the verge of being transferred to secondary school extremely poorly socialised, illiterate, with a history of significant risk events and his high level of educational needs unrecognised.

The next case study considers the unintended consequences of inappropriate therapeutic support based on so-called attachment therapies.

Case Study 3

C is a 5 year-old girl removed from her birth family aged 2½ to foster care following significant neglect but no maltreatment. She joined her adoptive family aged 4. C presented as very active, with tantrums, defiant behaviour, and poor concentration. She was given a diagnosis of oppositional defiant disorder. There was no evidence of RAD or DAD, nor indeed of attachment difficulties more generally as she had developed warm, nurturing and specific relationships with both carers. She was a bright but socially awkward girl with excellent literacy and language skills.

The family were offered an individualised parenting program based upon increasing sensitive responding to address her oppositional and disruptive behaviour. During this program, we observed a repetitive game in which C insisted that one parent lie down while she climbed out from between her legs and cried like a baby. C's parents reported disliking this game of rebirthing but

said they had been told by an attachment therapist that they must continue to play it otherwise it would "destroy the chance of forming an attachment forever". Her parents had also been forbidden to tell stories at bedtime and instead 'regress' C, feeding her milk from a bottle hidden in their shirt, as if breast feeding, and speaking only in nonsensical baby-talk. The parents were uncomfortable with these techniques and they specifically mourned the opportunity to play to C's strengths and evident pleasure in language and story-telling. Despite strong reservations they had deferred to their attachment therapist's expertise and stuck to their program religiously, albeit unenthusiastically and joylessly.

A school visit highlighted further problems. Unsurprisingly, C was attempting to recreate the "making babies game" game with her peers, who found it aversive and rejected her overtures. Her teachers and some parents found her behaviour inappropriately sexualised and had raised safeguarding concerns. Eventually it was necessary for C to move school. As part of the parent-training approach, to address the mild oppositional behaviour, the parents were encouraged to play with C in ways that all three enjoyed, at a developmentally appropriate level. They were also encouraged to have a normal bedtime routine, which included reading stories, and to cease the rebirthing and regression.

The so-called attachment intervention had inhibited the full development of an easy and enjoyable relationship between the carers and the child. It specifically prevented the family enjoying the normal tasks of bedtime routines such as storytelling, a characteristic associated with secure attachments at that age (Bus & van IJzendoorn, 1988) and so prevented her parents from playing to her clear strengths. Furthermore, by misunderstanding the developmental context of this child, the rebirthing had introduced an iatrogenic form of play into school that led to this socially awkward child having difficulties making the good peer relationships that are an essential part of this developmental stage. Although her case history revealed no sexual abuse, her behaviour, secondary to the bizarre attachment therapy, had been viewed as sexually inappropriate and risky by the school network.

There are any number of unusual treatments for the various attachment disorder problems we have come across amongst the population of adopted (and fostered) children we have seen in our clinic. Although we rarely see the now outmoded holding therapies, which have a substantial literature of concern relating to them, there remain variants of these, which involve regression components and bizarre approaches that border on emotional abuse, including, for example, restraining a child while reliving traumatic events, frequently accompanied with strong advocacy from the therapist that any other course would be certainly damaging (cf. Chaffin, et al., 2006; AACAP, 2005). Many of these bizarre interventions are characterised by insisting that adopted children be regressed to an earlier stage, but in doing so they deny the fact of the child's current chronological age and developmental stage. It also denies them the chance to access the age-appropriate interventions proven to work in similarly aged children. Wherever this belief in the therapeutic benefit of regression comes from, it does not come from attachment theory. Bowlby explicitly criticised regression approaches convinced by the evidence of developmental trajectories that continue through life rather than discrete stages to which children should be therapeutically regressed (Bowlby, 1988). While children with poorly developed emotional regulation skills or impaired social competence may express immature or developmentally inappropriate behaviours, especially when stressed or faced with unfamiliar situations, this is not the same as regression to an earlier and more 'genuine' developmental stage. Nor, of course, is it the case that children's need for nurture can only be given in such a regressed state.

A final case example serves to bring several of these themes together to highlight what can go wrong when a child is inadequately assessed and treated over the whole of childhood and the negative impact this can have on the child's developmental trajectory into adulthood.

Case Study 4

D is a 17 year-old girl, removed to foster care at age 2 due to neglect secondary to parental substance misuse, who entered her adoptive family aged 4 via a private agency. Despite longstanding problems, assessments in her local CAMHS had been declined because it was believed, *a priori*, that as she was adopted her difficulties would be an attachment issue and therefore not a

frank mental health problem amenable to treatment. The family sought treatment from private and voluntary agencies and received various attachment therapies. D finally arrived in our clinic shortly before her 18th birthday, presenting with a complex mix of serious symptoms including extreme fluctuations of mood, serious violence, stealing from home, running away for days at a time, frequent self-harm and risky behaviour with antisocial adults, as well as a long history of school failure.

A multi-disciplinary assessment revealed global intellectual disability and, over and above this, a specific learning disability of scholastic skills. Unfortunately diagnosis of these intrinsic difficulties came too late to get her accepted into a learning disability service or to attempt to remediate her school failure. The assessment also revealed a history of mild oppositional problems, developing into a severe and pervasive conduct disorder, some residual ADHD symptoms and evidence of longstanding depressed and labile mood. None of these had been previously identified because her behaviour had been construed as a global attachment disorder presentation rather than at the level of the mainstream diagnoses that would have rendered her suitable for evidence-based CAMHS interventions and statutory educational support.

Shortly after the assessment, D went out to celebrate her 18th birthday, but failed to return home for several days. She was later found by police in the course of an unrelated criminal investigation in a house of known offenders. She was highly distressed, agitated and bleeding from self-inflicted injuries. The police took her to adult mental health services, where she was kept safe before being discharged with a provisional diagnosis of borderline personality disorder.

The *a priori* formulation of this girl's difficulties as an attachment disorder functioned to dismiss a conventional assessment and possible treatments at a much earlier and more hopeful point of her trajectory. By the time a comprehensive assessment was conducted it was too late to engage educational and child learning disability services, and also too late to attempt to stem the development and stabilisation of relatively common childhood difficulties into adulthood and to see them transformed into an

adult diagnosis. In this instance, the girl went out to celebrate her majority with an unspecified attachment disorder but came back as an adult with a diagnosis of borderline personality disorder, even though there was little difference in her presentation over the previous few years. However, on reaching 18 adult services did not formulate her difficulties as an attachment issue, but saw her as she presented in the here and now and not in an over simplistic understanding of her early history.

What links these case vignettes is the assumption of the normality of an attachment disorder in adopted children, by virtue of their history and without consideration of their individual circumstances, history and presentation. It should be noted that these processes are not restricted to adopted children and we have seen similar processes operating with looked after children. Adoptive parents have a strong desire to address attachment issues in their children (Barth, et al., 2005), and this is understandable because developing new and therapeutic attachments is a crucial process for these families. However, clinicians have a duty to give these parents the best possible care and advice, in a sensitive way, always considering what the best explanation is for the current presentation and avoiding the easy-option of an unspecified attachment disorder (Chaffin, et al., 2006; AACAP, 2005). In our experience, one of the major risks of resorting to an unspecified attachment disorder formulation is that it can leave systems feeling helpless or with excuses to avoid engaging with families. Below we propose some provisional recommendations for working with adoptive families, based in part upon the recent US guidelines for working with maltreated children with attachment difficulties (Chaffin, et al., 2006; AACAP, 2005).

- Recognise that Reactive and Disinhibited Attachment Disorders are very rare disorders and that evidence of even the most pathogenic early experiences is insufficient to warrant such a diagnosis, even in the context of extreme behavioural and emotional problems. The diagnoses relate to pathological and observable distortions in attachment-specific behaviours, and the relevant behaviours should be present in infancy and early childhood, e.g., before the age of 5. Typically, it is hard to justify a diagnosis of either DAD or RAD where you can see evidence of a selective attachment to a carer, to whom the child seeks proximity and comfort, even if the overall relationship is of a poor or non-optimal quality (Prior & Glaser, 2006). Furthermore, very little is

known about how RAD or DAD might present in older children and adolescents and extra caution should be exercised making these diagnoses in older children, even when other more common diagnoses have been ruled out.

- Adopted children with emotional or behavioural difficulties will benefit from a thorough multidisciplinary assessment, in which the developmental and caregiving history is assessed, and a formulation devised that considers the range of likely problems, especially those that have been shown to be particularly common in children with histories of early pathogenic care, including conduct disorder, ADHD, and other neurodevelopmental problems, as well as mood and of course the consequences of trauma including PTSD. All of which are likely to be seen far more frequently than pure RAD or DAD. While attachment disorder very rarely features in the primary diagnoses in our clinic, the recognition of attachment difficulties is very frequently an important part of the comprehensive formulation.
- Many adopted children will benefit from an intellectual assessment combined with formal assessment of scholastic attainments. In common with looked after children, many adopted children are likely to have difficulties accessing education and they are also likely to be at increased risk of specific and general learning disabilities. There is increasing evidence that early pathogenic care and maltreatment can have varied consequences for neurodevelopment and physiological regulation (McCrory et al, 2010; Dozier, Peloso, Lewis, Laurenceau, & Levine, 2008) and access to comprehensive neuropsychological assessment is likely to be helpful for a significant number of adopted children.
- For adopted children who present with behavioural problems, parent training is the indicated intervention, and in recognition of the complexity in such families such interventions may be best delivered either 1:1 or via programs specially tailored to this client group. Parent training simultaneously increases the carer sensitive responding by which secure attachments are known to develop (Bakermans-Kranenburg, et al., 2003) and is also the recommended intervention for behavioural difficulties in maltreated children (Chaffin, et al., 2006; AACAP, 2005). Indeed, an evidence base is beginning to be established for parenting training with RAD cases (Buckner, Lopez, Dunkel, & Joiner,

2008). Parent training in complex cases such as these could include adjuncts such as behavioural family therapy, psychoeducation and cognitive work with parents (Scott & Dadds, 2009).

- Working with systems e.g., with schools or social care to ensure a consistent approach that is based on the evidence or at least best practice, as would be done for a birth child. This is likely to involve some psychoeducation with other professionals, e.g., to ensure no blurring of the consequences of maltreatment and neglect with a child's attachment, nor overemphasise the extent of or the inevitability of problems (e.g., Prior & Glaser, 2006).
- Children with histories of early pathogenic care may well also need long-term intervention and support, perhaps with therapies for which the evidence base is not currently clear, but each case needs to be formulated on the basis of the individual's current presentation, once frank difficulties have been assessed and treated according to recognised and valid criteria.
- For the children themselves, there is the opportunity for individual work on mood and trauma focussed CBT but also more general work around problem-solving, social skills and emotion-regulation, where indicated.
- Finally, we believe it is unlikely that the popular research based assessments regarding the patterns of attachment organisation (e.g., Ainsworth, Blehar, Waters, & Wall, 1978; Green, Stanley, Smith, & Goldwyn, 2000) are going to be sufficient in themselves to give an adequate formulation of the complex emotional, neurodevelopmental and behavioural issues that can present within the population of adopted children. Gold-standard attachment assessments are not designed to be directly clinically informative and do not map onto recognised diagnostic categories, nor do the various classes of attachment quality they provide give reliable information about the risk of psychopathology, nor an index of current parenting. Indeed, emerging recommendations for the clinical assessment of attachment disorders emphasise multiple observations, across multiple settings (AACAP, 2005; Zeanah & Smyke, 2009; McLaughlin, Espie & Minnis, 2010).

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